

April 25, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-0547-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in neurosurgery. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a 42 year-old female who was injured in a work-related slip and fall accident on ___. A MRI of her lumbosacral spine performed on 2/16/02 revealed facet arthrosis, a 2 mm broad based disc protrusion at L5-S1 and 1 mm eccentric bridges of the annulus on the right and left of midline at L4-5. A MRI of her thoracic spine performed on 6/21/02 revealed small disc bulges at T7-8, T8-9, and T9-10 with the annulus mildly effacing the thecal sac at each of these segments, mild disc desiccation from T1 through T9 and mild kyphotic deformity of the thoracic spine. The patient has been evaluated by a pain management specialist, an orthopedic surgeon and a neurosurgeon. She has been diagnosed with lumbar intervertebral disc herniation. Treatment has included chiropractic treatment, physical therapy, active exercises, a series of 3 lumbar epidural steroid injections and medications.

Requested Services

Lumbar discogram

Decision

The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision

The ___ physician reviewer indicated that this patient is a 42 year-old female who injured her back in a work-related accident on ___. The ___ physician reviewer also indicated that she has been diagnosed with lumbar intervertebral disc herniation. The ___ physician reviewer explained that lumbar discogram is a useful tool for the confirmation of the pain generator in a significantly damaged disc.

However, the ____ physician reviewer further explained that that the efficacy of lumbar discogram for identification of the source of a patient's pain is unproven. The ____ physician reviewer also indicated that the reliability of this discography has not been established. Therefore, the ____ physician consultant concluded that the requested lumbar discogram is not medically necessary for diagnosis and treatment of this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 26th day of April 2003.